PLEASANTDALE AMBULATORY CARE

61 D Main St • West Orange •NJ•07052 •Tel: (973) 324-2280 •Fax: (973) 324-2287

SURGICAL BOOKING SHEET

(Please Print) Date: _____

Name: _____ SS#: _____

Home Address: _____
Street City State Zip

DOB: _____ Age: _____ Sex: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Employer: _____

Address of Employer: _____

Surgical Information *(Must be completely filled out by Surgeon's office)*

Procedure: _____ CPT: _____

Procedure: _____ CPT: _____

Diagnosis: _____ **ICD-10** _____

Surgeon: _____ Assistant: _____

Surgeon's Phone: _____ Surgeon's Fax: _____

Requested Surgery Date: _____ Requested Surgery Time: _____

Type of Anesthesia: _____ **Equipment/Supplies Required:**

Medical Doctor to contact regarding PAT's: _____

Phone_____ Fax: _____

Transportation Required: Special Needs: _____

Length of Surgery: _____ C-Arm Required:

Patient Insurance Information: ***(Must be completed by Physician/Surgeon's office.)***
Please include a legible copy of both sides of patient insurance card with this paperwork.

Primary Ins. (hospital): _____

Policy ID:_____ Group: _____

Phone: _____Address of INS: _____

Were Out-of Network Benefits verified? _____Yes _____No Verified by: _____

Precert #: _____ (if necessary)

Secondary Ins. or Supplemental: _____

Policy ID: _____ Group: _____

Phone: _____ Address of INS: _____

Were Out-of Network Benefits verified? _____Yes _____No Verified by: _____

Precert #: _____ (if necessary)

If patient is not the policyholder please complete: (MUST FILL OUT)

Name of Policyholder: _____D.O.B. of Policyholder:

Relationship to patient: _____

Employer of Policyholder: _____

Address of Employer: _____Phone: _____

******COMPLETE THIS PORTION IF IT IS ACCIDENT RELATED*******
****** LETTER OF PROTECTION TO BE INCLUDED IF APPLIES & MUST BE ADDRESSED TO PLEASANTDALE*******

PIP / SLIP & FALL / WORK COMP ONLY:

Attorney Name: _____Attorney Phone: _____

Ins. Name: _____Ins. Address: _____

Claim Number: _____ **Date of Accident**: _____

State of Accident: New Jersey ( ) New York ( ) Pennsylvania ( )
Other ( ) _____

Adjusters Name _____ **Ins. Phone:** _____

***PIP LIMIT:** _____ **AMOUNT USED**: _____ **AMOUNT REMAINING**: *

Accident / Injury – Were You ( ) Passenger ( ) Driver ( ) Pedestrian

Vehicle Involved ( ) Own Car ( ) Family Car ( ) Commercial ( ) Motor Cycle